Folder | Contents | Notes (0/0)

Folder: Current Case Plan

Logs (0)

Details

Name	STEVEN ALFANO	SSN	099-44-9648	DOB	01/14/1958
Account Name	WEILL MEDICAL COLLEGE	Account #	NYK0001972	Incurred Date	08/06/2000
Claim Manager	Mark Sodders	Incident #	513554	Claim Eff Dt-Status	01/21/2003 - Active

Hide Details

Claim Strategy 11/09/2004 11:51:09 AM a66816 Isa

Claim Status Comments

```
11/03/04 staffed claim with MCM.  Based on recview of current medical, and PAA, run
exploratory TSA on L/R provided.  Concurrently, send APS to CX for COD, LOV.  If TSA
positive, send to AP for comments.
MDSodders  CX
```

Level of Functional Capacity

With Restrictions

Restrictions and Limitations

Subjective/Objective Findings/Treatment

Outstanding Issues and Follow-up Dates

Strategy

11/03/04 staffed claim with HCM. Based on recview of current medical, and PAA, run exploratory TSA on L/R provided. Concurrently, send APS to CX for COD, LOV. If TSA positive, send to AP for comments.
MDSodders CM

Active Contents

Type	Due Date	Created By	Assigned To	Name
LTD	06/06/2008		Mark Sodders	ALEANO,STEVEN -- 099449648 -- 01/14/1958

Created: 04/03/2004 11:57 AM

7/31/2003

Claimant Name: Steven Alfano SSN: 089-44-9648 Page #2

CURRENT CASE PLAN

7/31/03 - Clmt is 44 yr old wage and salary mgr for Cornell university medical college. Incur date - 6/6/00. Claim was denied as meds in file did not support clmt id through the waiting period. Decision was appealed and upheld. Clmt's atty appealed decision and it was overturned. Meds in file support symptomatic multilevel spinal stenosis and nerve root impingement supported by clinical exam findings and peer review. All of his Dr's (4) have indicated that clmt needs surgery. Clmt has opted for conservative tx. There was a peer to peer review on 12/10/02 which supports clmt is id. At At this time, we are requesting medical updates. Current DQ is in file. Possible surveillance in the future to make sure the is not active. Also do tpc. R. Castellon Sr. CM

2/3/2003 - received meds from Dr. Mojadidi. meds show clmt had shoulder and hip arthroscopy surgery. surgeries were helpful an clmt is doing much better. still waiting meds from Dr. Roach.

12/28/2000

GENERAL INFO.

Date Claim Rec'd	12/08/00	Date of Hire	08/05/1991
Policy Eff. Date	07/01/1989	EE Class	1
Policy Canceled?	n	Date elected	09/05/1991
Initial EE (Y/N)	n	EE Eff. Date	09/01/1991
Eligibility WP	1 month	Eligible? (Y/N)	y
Incpt Date	06/06/2000	PCL Descr	3095
Inv. PCL (Y/N)	n	Inv Dates	
Ben. Start Date	12/03/2000	Any Occ. Date	01/13/2023
DOB	01/14/1958	Ben Term Date	01/13/2023
PD Age Rec'd?	n	FMI (Y/N)	y
MI Limit (Y/N)	y	W.O.P (Y/N)	n
SS Policy Lang:		Primary/Full	full
R/A Rec'd(Y/N)?	n	Freeze (Y/N)?	y

Other benefits: **Amount/ Status:**

Short Term Disability (01)	2894.41	thru 12/6/2000
Primary SSDI w/ Freeze (04)		
Dep.SS w/ Freeze (06)		
Gov't/State Dis Benefits (16)		
WC/Jones Act (18)		
Salary Continuance (19)		
Other:		
Other:		

Note: EWP -- Watch for 1st of month following DOH, etc.

BENEFIT INFORMATION

BME/Salary	$5,933.32		
Gross Benefit	$3,560.00	Override Benefit	
Basic %	60%	Override %	
Minimum	$100.00	Maximum	$15,000.00
EE Contribution %	50	Pre/Post	post

EMPLOYER INFORMATION

Policy Number	NYK 1972
Policy Name	Weill Medical College
PH Address	
Phone #	212.746.1035
Contact Name/ Title	Rosemary Cluc

MEDICAL INFORMATION

Initial DX:	Radiculopathy
ICD-9/DSM IV	722.52
Surgery/Hosp	
Accident? (Type?)	
Work Related (Reported?)	

Attending Physician	Phone:	Fax:
James Farmer, MD	212.606.1691	212.774.2909
Stephen Sonsa, MD	212.844.8490	212.844.8481
Robert Snow, MD	212.746.2630	212.746.3529
Steven Digiovanni, MD	212.434.3432	212.434.3358
Andrew Schiff, MD	212.746.2879	212.746.4609
Sean McCance, MD	212.546.9285	212.546.9288
Michael Alexiades, MD	212.734.1288	212.288.1524
Thera - Ex	914.476.0951	

OCCUPATIONAL INFORMATION

Occupation	Wage and Salary Manager
Job Description (Y/N)	y
Occ. Desc. - Sed., Light	
Med., Hvy, Very Hvy	sedentary
Education <8th Grade	
<12 Grade	
H.S. Diploma / GED	
College - #Years	
Degree (List titles)	
Specialty, Certificate, or License	
Experience	
RTW Language	

CLAIMANT INFORMATION

Claimant Name:	Steven Alfano	Social Security #	099-44-9648
Address	3800 Waldo Ave Apt 13-G	Phone/ Fax #	718.884.2067
	Bronx, NY 10463	Spouse Name	Eva Alfano
Cx Age @ Dis.	42 Clmt Age 62 01/14/2020	Spouse SS#	065-60-9638
Spouse DOB	05/25/1962	Spouse Age 62	05/25/2024

Dependent Name	DOB	Date Age 18	Age 25 (disabled)
Andrea	10/01/1992	10/01/2010	10/01/2017
Michael	05/18/1995	05/18/2013	05/18/2020

Additional Information:

alf9548

EE: ALFANO, STEVEN	SSN: 099-44-9648	DOI: 06/06/2000	ER: WEILL MEDICAL COLLEGE OF CORNELL UNIVERSITY(DIS)	ID: 854973378660580
WCC:	LTD:	STD:	ICMS:	Other:

Current Case Plan

Add a New Current Case Plan Entry Bottom of Page

Paperwork sent as an appeal was set up by Intake as new claim but was recognized as a "no load". Appeal was tracked to DAllas Appeals Team on 6/4/02. Copy of correspondence will be again referred & this Unilnyx file closed out at assigned in error. MR
06-17-2002 08:02 AM - RYAN, MARY

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I am overturning the prior denial. This is a voluntary appeal. Cx was 42 years old at time of disability. ID is 06/06/00. Cx was a Wage and Salary Manager, which was considered to be sedentary. Peer Review was done by an orthopaedic doctor. Dr. Trotter did the Peer Review. Dr. Trotter stated that the medical documentation supports cx's inability to perform his occupation from 06/06/00 forward. Also the medical records indicate that the cx has a combination of symptoms, exam abnormalities, including ancillary test results that support ongoing diagnosis of severe multilevel spinal stenosis and nerve root impingement. This is severe enough that would preclude cx from performing his full time occupation from ID forward. Dr. Trotter stated from his review of the records, no matter what position cx assumes, he has symptomatic spinal stenosis and nerve root impingement on the basis of both soft tissue (discopathy and bony osteophytes). Nerves at the level of L5-S1 appear to be resulting in ongoing radiculopathy in particular of the LLE. Cx has not responded to nonoperative treatment and cx appears to have an indication for surgical intervention. Cx's overall pain level severity correlates with sx and exam findings. Cx's overly large body habitus may well have contributed toward his ongoing relatively severe spinal pathology. Dr. Trotter stated that the claimant appears to have significant ongoing symptomology of back pain and lower extremity radiculopathy that would not allow cx to reasonably perform his occupation on a full time basis. Cx has a well documented case of spinal stenosis with radiculopathy resistant to nonoperative means and appears to have a significant correlation overall between the sx, exam findings, and ancillary test results rendering cx unable to perform his occupation. COntinued on next entry...
01-14-2003 01:47 PM - BHARADWAJ, MEDHA

Top of Page

continued from previous entry: Based on the medical evidence in file supporting cx's inability to perform his occupation, along with the peer review findings, I am overturning the prior denial. File returned to core team for further handling. SS award in file. Core team to ensure that the offset is put in place and do calculations, manage claim, etc.. Gary Person reviewed file and agreed.
01-14-2003 01:48 PM - BHARADWAJ, MEDHA

Top of Page

Add a New Current Case Plan Entry

File Plan
Claimant: Steven Alfano
SSN 099-44-9648

12-5-02 MC completed referral to Intracorp for Ortho/PR as requested by ACE. MC will f/u by 12-23-02.
Karen Haley RN, CLNC

12-30-02 MC received Ortho/PR report back from Intracorp. Reviewer found that medical records do identify severity of condition that would preclude cx from performing at the sedentary level. Reviewer noted that cx has significant symptomatic spinal stenosis and nerve root impingement and claimant has not responded to conservative treatment modalities. Please see report for details. Medical sufficient to support cx's inability to function in the sedentary capacity during the time period of 6-6-00 through present. MC discussed with ACE and file returned.
Karen Haley RN, CLNC

File Plan
Claimant: Steven Alfano
SSN 099-44-9648

12-5-02 MC completed referral to Intracorp for Ortho/PR as requested by ACE. MC will f/u by 12-23-02.
Karen Haley RN, CLNC

01/23/2001

Claimant Name: Steven Alfano SS#: 099-44-9648 Page #1

CURRENT CASE PLAN

12/28/2000 42 year old male, wage & salary manager with DX of low back pain. CX noticed increased in low back pain 4/2000. Disability commenced 6/6/2000. AP reports lumbar degenerative disc disease. Cx reports back pain with interuption in his sleep. Current TX - physical therapy 3 times per week. CX treated with Dr. Scelsa 7/20/2000. Exam showed negative Patick's movement. SLR negative. Neuro exam - strenght normal. Slight antalgic gait. Negative Romberg. Bilat peroneal and tibial motor conduction studies normal. Left tibial and bilat peroneal F-wave minimal latencies were prolonged. Right tibial F-wave minimal latencies - normal. Bilateral sural & peroneal sensory responses - normal. Bilateral tibial H-reflex latencies were prolonged. Needle EMG of bilat gluteus maximus , left leg, and L5 paraspinal muscles showed no spontaneous activity. AP reports CX has left S1 radiculopathy. CX to f/u for 3rd epidural injection and released to work. CX f/u with Dr. Snow 8/23/2000. SLR + 45 degrees. + pain with extension and flexion of the low back. AP recommends surgery. CX f/u with Dr. Farmer 8/31/2000. Exam showed normal gait. Exam of L-spine showed no tenderness to palpation. Able to forward flex within 6 inches of the floor. Extension 30 degrees. ROM hips is full and painless. Recommended that CX do PT and continue to take anti-inflamm. 9/14/2000 eval CX reports PT exacerbated pain. Exam showed L-spine non-tender to palpation. + pain with forward flexion. Neuro exam normal. CX reports pain limits him on a daily basis. AP recommend discogram then new MRI. PAA completed by Dr. Snow showed CX able to lift up to 20 lbs frequently and 50 occasionally. CX able to sit, stand and walk up to 2.5 hours each. PAA completed by Dr. Scelsa indicated CX is able to sit and stand up to 5.5 hours each and walk up to 2.5 hours.

No eligibility or pre-x issues as proof of enrollment is on file and CX elected coverage 1991.

Requested progress notes. Still awaiting notes from Dr. Farmer, Dr. Digiovanni, Dr. Schiff, Dr. McCance, Dr. Alexiades and rehab facility. Will f/u 1/5/2001.
May consider FCE for evaluation of CX current limitations as CX was released to work following 7/20/2000 evaluation and did not f/u with AP. It appears based on PAA completed by Dr. Snow and Dr. Scelsa that CX has the ability to perform a sedentary job. PAA's were based on one evaluation only and CX did not f/u with these physicians.

Outstanding issues: Will call to f/u on med 1/5/2001 if not received.

Lara D'Ambrosio - Case Manager

01/8/01 Called to f/u on med requests. Re-faxed request to Dr. Alexiandes. and left messages at Dr. Digiovanni, Dr. Shiff, and Dr. Farmer's offices. Rec by 1/17/01.

Outstanding Issues: F/U if med not rec'd by 1/17/01.

Shannon Bailey - Case Manager

1/9/2001 Rec'd evaluation with Dr. McCance. CX seen on 8/17/2000. CX seen for eval of low back pain radiating down into left leg with numbness of both feet. CX reports loss of strength with walking. CX is 6'4" and weighs 300 lbs. Exam showed decreased sensation in the left L5 and S1 distribution. SLR negative. Hip ROM pain free. + pain with pressure palpation of the L5 vert. AP recommends surgery. Notes from Dr. Schiff indicate CX seen on 10/16/2000. Given Celexa for depression. CX f/u 10/23/2000 - sleeping better.

Outstanding issues: F/u on med req from Dr. Alexiandes, Farmer, and Digiovani 1/17 if not rec'd.

Lara D'Ambrosio - Case Manager

1/23/2001 Rec'd med from Dr. Alexiandes. CX treated with AP 6/5/2000 and 7/31/2000. Exam on 6/5/2000 showed norma

alf9648

02/06/2001

Claimant Name: Steven Alfano SS#: 099-44-9648 Page #2

CURRENT CASE PLAN

1/23/2001 con't >>> heel/toe, tandem gait. Decreased ROM LS spine. MRI showed moderate to severe L5-S1 spondylos and mild impingement on the inferior aspect of the left L5 nerve root and moderate L5-S1 spinal stenosis. F/u on 7/31/00 back pain still severe after 2 epidural injections. CX referred to spine surgeon for possible fusion.

Called Thera-Ex to f/u on request for PT notes. Notes should be rec by 1/24/2001
Called Dr. Farmer to f/u on progress notes - notes should be faxed by 1/24/2001

Outstanding issues: Will f/u with AP and PT 1/25/2001 if notes not rec'd. Upon receipt of med, will confer with MC

Lara D'Ambrosio - Case Manager

1/31/2001 Held staffing. Discussed issues of limitations and restrictions and conservative TX. Will send CX for IME as CX was released to work by neuro but does need surgery in the future.

Called CX to advise of IME. Asked about PT. CX stated that he only went to PT once. Current TX consists of diet and R
Referred file to be copied. Will refer to MC to schedule IME.
Lara D'Ambrosio - Case Manager

02/06/2001 Medical Consultant
File reviewed in its entirety, in preparation for IME.
Review reveals cx's incur date is 6/6/00. Dr Farmer, ortho, who signed the APS on 11/20/00, saw the cx for the first time on 8/31/00. Writer questions how this MD can certify disability for a period of > 2 months prior to seeing the cx.
CM requested OV notes from cx's PCP, Dr Schiff from 4/00 through the present. Notes sent were dated 10/16/00, and 10/23/00. No subjective complaints are noted, on 10/16. CX's BP is elevated to 160/100, and cx is started on Zestril in addition to Norvasc. ROS only cardiopulmonary. No P.E., and cx was also started on Celexa 20mg.
Cx returned on 10/23, subjective documents: "42yo man with doing well on Celexa, sleeping better and BP well controlled on Zestril". Objective: BP" 130/100 wt. 304lbs." In list of current meds writer notes that cx is taking no medications for analgesia.
Cx is then seen by a Dr Alexaides, ortho MD, on 6/5/00 who specializes in knee, hip, and shoulder surgery. At this app't cx reports > L lumbar radiculopathy for 2 weeks, and reports Motrin is providing only minimal relief. P.E. at that app't, is documented as normal heel/toe walk, and tandem gait, decreased ROM of LS spine, motor strength 5/5, DTRs 1+ in knee and 2+ in ankles. CX was sent for a MRI of LS spine on 6/9/00. See CM's entry dated 1/23/01 for MRI results.
MD writes "He is unable to work at this point". Cx is seen in f/u on 7/31, neuro intact, cx has difficulty walking on toes.
Cx is seen by a Dr McCance, spinal surgeon, on 8/17/00. P.E. documented as difficulty with heel walking on L. DTRs are 2+, and 1+ at the L ankle, pain with pressure at L5, and pain with lumbar ROM with extension. Dx: Discogenic LBP, and L L5-S1 radiculopathy. A fusion with decompression of L5-S1 was recommended.
Cx seen in consult by a Dr Scelsa, neurologist, on 7/20/00. MD performed EMGs, and P.E. which document the following: "Clinical/Electrophysiologic Impression: There were nonspecific neurogenic abnormalities in both legs of uncertain significance. Late responses were prolonged bilaterally. These findings did not clearly differentiate bilateral L5/S1 radiculopathies from mild polyneuropathy. There was not definitive electrophysiologic evidence of either. Taken together, the clinical and electrophysiologic features suggest the patient has left S1 more than L5 radiculopathy. There was no associated weakness or reflex change". Cx was to f/u for a third ESI, and started on Pamelor and Ultram.
"He was told that he could return to work, and that he should get up form his desk a few times per hour to stretch and walk around. He was also told he should avoid lifting anything heavy (greater than 10 pounds)". Cx was to f/u in 6 weeks.
PAA completed by Dr Scelsa on 12/18 documents cx is capable of sedentary work.
Cx seen for the first time by a Dr Snow, neurosurgeon, on 8/23/00. P.E documents + SLR bilaterally at 45deg; motor/sens exam normal; pain with flexion and extension; DTRs 2+ and symmetrical except for absent ankle jerk bilaterally. >>CONT>

alf9648

04/12/2001

Claimant Name: Steven Affano SS#: 099-44-9648 Page #3.

CURRENT CASE PLAN

02/06/2001 Medical Consultant >>>CONT FROM PREV. PAGE>>>
Impression was: L5-S1 radiculopathy, L>R., secondary to stenosis. Cx was to think about a lumbar laminectomy.
PAA completed by Dr Snow on 12/15/00 documents cx is capable of sedentary work.
Cx was seen in f/u by Dr Farmer, ortho, on 11/7. MD documents no change in ROM, and neurologic exam, "stable from a motor and sensory standpoint. Neural tension signs are negative." Cx requested to return to PT, and a RX was given. Vioxx was renewed, and cx was to f/u after completing his course of PT. "He is not having any night pain".
Numerous requests from P.T facility revealed cx was seen for one visit only on 9/9. Initial PT eval is illegible, and there has been no further f/u on the part of the cx.
Writer believes that current medical in file supports cx's ability to perform a sedentary JD. We have three PAAs complete by neurosurgeon, neurologist, and orthoped who document cx is capable of performing sedentary work.
File returned to CM with above recommendation and request for Occ requirements of JD. If JD is truly sedentary, we do not have R/Ls which support cx's inability to perform JD. Please advise writer if IME still needs to be done.
File returned to CM.
Linda Cufari, R.N.

2/12/2001 File reviewed. CX does not satisfy the definition of DBL as the 180 day benefit waiting period had not been satisfied. CX was released to work 7/20/2000 and PAA's indicate that CX is capable of performing sedentary work. Per call to ER, CX's job does allow him to get up and walk around as needed. ERISA sent.

Lara D'Ambrosio - Case Manager

3/21/2001 Rec'd letter of appeal from attorney. No additional med provided. Attorney stated that additional med will be submitted and would like additional time to do so.
Referred to appeals team.

Lara D'Ambrosio - Case Manager

9/23/01 Reviewed file on appeal. Cx last worked 6/5/00. First visit same day, AP to cx to stop work but no clinical findings on exam. Cx released to RTW by another Dr 7/20 after EMG performed (showed L S1 > L5 radiculopathy). Cx saw a variety of other physicians, most only once, for surgical opinions and consultation. None provided significant findings on exam. MRI shows mod-severe spondylosis L5-S1, mild impingement of the L L5 nerve root and moderate stenosis L5-S1. Cx has retained atty for appeal. Atty has not submitted any new information but says they will.
PLAN – follow for additional information. Issue delay letter at 30 days, make decision at 60 if nothing else received.

JHoughton, Case Manager

4/12/01 Received another letter from atty requesting 60 more days for cx to submit medical information. Currently, info in file does not support that cx is disabled. I will decide at this time to uphold decision to deny claim. I will inform atty that although I have upheld decision, I will consider any information he will submit.

JHoughton, Case Manager

P. I. MANAGEMENT WORKSHEET	DATE: December 28, 20	LTD
RCM: Steve Mana	CLMNT: Steven Alfano	STD
TL: Abbe Eyte	SS#: 099.44.9648	PW
CM: Lora D'Ambrosio	P/H: Weill Medical College	
CPC: Maria A. Casini	ACCT#: NYK 1972	
COMPLIANCE		
1. Acknowledge Receipt of Claim (10 Days	Y	rec'd 12/7/00. ack'd 12/8/00
2. Alert Other Benefits (CA & OH)	n/a	
3. 30 Day Compliance		
1st Delay Sent?	n/a	first delay due by 1/6/01. This is a Saturday, please send prior
2nd Delay Sent?	n/a	
3rd Delay Sent?	n/a	
4th Delay Sent?	n/a	
5th Delay Sent?	n/a	
4. Communication Response (10 days)	n/a	
5. Denials (CA;IL;NH;AK;IN; NE;OH; etc.)	n/a	
Total Compliance Opportunities:	1	
Total C.J.'s:	0	
Case Manager Accountable:		
Team / Office Accountable:		
Summary/Comments		
Compliance Checklist was on File		

JUL. 24. 2003 11:25AM CIGNA DALLAS NO. 315 P. 1

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life · Accident · Disability

Transmit to FAX number	Date	Time	Total number of pages (including this sheet)
212-439-6855	July 24, 2003	12:00 p.m.	4

Name Dr. Michael Alexiades	Name Roberto Castellon
Company	Department CIGNA Disability Management Solutions
Phone 212-734-1288	Phone 1.800.352.0611 Extension 9608
Address 159 E 74 St. New York, NY 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

Comments

RE: Steven Alfano
DOB: 1/14/58

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income), we are in need of the following information:

- **Copies of your progress notes, including diagnostic test and lab results, from 1/1/01 to the present.**
- **A completed Physical Abilities Assessment form (attached).**

We ask that you kindly respond by **8/7/03** to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your **tax identification number.** If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Roberto Castellon
Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial: 860.731.2907

MICHAEL M. ALEXIADES, M.D., P.
159 EAST 74TH
NEW YORK, N.Y. 10021
TELEPHONE (212) 734-1288

04/22/02 Mr. Steven Alfano returns with increasing pain in his left shoulder which previous MRI showed tendinopathy. In addition he is having some right anterolateral hip pain. Right shoulder is doing relatively well. We discussed options an he will consider a left shoulder arthroscopic procedure. In the interim we will get films of the right hip.

07/08/02 Mr. Steven Alfano returns post shoulder arthroscopy. Range of motion and strength are good. Plan: Continue rehab on his own. The patient will return for follow up in six weeks. At that point we will discuss his right hip and possible arthroscopy. He saw Dr. Springfield who has cleared the hip from an oncology point of view.

09/23/02 Mr. Steven Alfano returns post shoulder arthroscopy. Occasional AC joint discomfort but strength and range of motion are excellent. Plan: Continue exercise regimen. The patient will return for follow up in the future prn. He wished to discuss hip arthroscopy. The material risks, benefits and alternatives were discussed with the patient who understands and will decide.

03/24/02 Mr. Steven Alfano returns for follow up and his right hip anterolateral pain persists. Physical Examination is consistent with his labral tear. Plan: We discussed his options and he wishes to undergo arthroscopic hip surgery. The material risks, benefits and alternatives were discussed with the patient who understands and wishes to proceed.

04/24/03 Mr. Steven Alfano returns one week post arthroscopy. He has no pain; good motion. He is walking well. Wound are fine. Sutures are removed. Plan: Continue home exercise program. The patient will return for follow up in six weeks.

05/22/03 Mr. Steven Alfano returns for follow up and his hip is doing great. He has no complaints; good motion. Plan: The patient will return for follow up in the future prn.

MICHAEL M. ALEXIADES, M.D., P.C.
159 EAST 74TH
NEW YORK, N.Y. 10021
TELEPHONE (212) 734-1200

04/22/02 Mr. Steven Alfano returns with increasing pain in his left shoulder which previous MRI showed tendinopathy. In addition he is having some right anterolateral hip pain. Right shoulder is doing relatively well. We discussed options an he will consider a left shoulder arthroscopic procedure. In the interim we will get films of the right hip.

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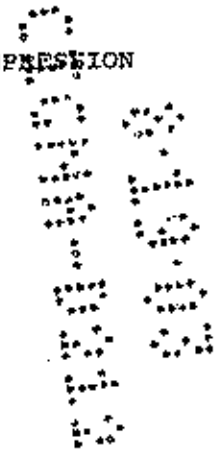
4/16/03: LEH "AMB"
4/16/03: SURGERY - RIGHT HIP ARTHROSCOPY, LABRECTOMY
DISCHARGED

MICHAEL M. ALEXIADES, M.D., P.C.
159 EAST 74TH STREET
NEW YORK, N.Y. 10021
TELEPHONE (212) 734-1250

04/22/02 Mr. Steven Alfano returns with increasing pain in his left shoulder which previous MRI showed tendonopathy. In addition he is having some right anterolateral hip pain. Right shoulder is doing relatively well. We discussed options an he will consider a left shoulder arthroscopic procedure. In the interim we will get films of the right hip.

6/13/02: LHH "AMB"
6/13/02: SURGERY - LEFT SHOULDER ARTHROSCOPIC DECOMPRESSION
AC RESECTION
DISCHARGED



MICHAEL M. ALEXIADES, M.D., P.C.
159 EAST 74TH STREET
NEW YORK, N.Y. 10021
TELEPHONE (212) 734-1288

06/05/00 Mr. Steven Alfano returns complaining of lumbar radiculopathy into the left leg for the last couple of weeks. It has gotten quite severe. He is taking Motrin with only minimal relief. Physical Examination reveals normal heel/toe/tandem gait; decreased range of motion of the LS spine; motor is 5 out-of 5; reflexes are 1+ both knees, 2+ both ankles. Plan: We will get an MRI to evaluate for a herniated disc. He is unable at this point to work. We will discuss treatment options after the test.

07/31/00 Mr. Steven Alfano returns with persistent low back pain with occasional numbness in the left leg. He saw a neurologist who felt he had some nerve damage but did not justify surgery. However, his back pain is quite severe despite two epidural injections. He is neurologically intact today although he has difficulty with toe walking. Plan: My recommendation is that he see a spine surgeon for possible fusion at L5 - S1.

05/24/01 Mr. Steven Alfano returns for follow up with recurrent right shoulder pain for the last couple of months. He has been doing some weight training to try and build up his shoulder and that may have aggravated it. He has also been going to physical therapy for his back which has gotten worse. He is contemplating surgery with Dr. Farmer at The Hospital for Special Surgery. Physical Examination today is consistent with impingement. He has some crepitus on range of motion. After discussion the patient was injected with Lidocaine and Depo-Medrol. Plan: If symptoms recur we will get an MRI.

11/14/01 Mr. Steven Alfano returns for follow up. Shoulder MRI on the left shows inflammation but no tear. After discussion the patient was injected with Lidocaine and Depo-Medrol. Plan: We will see how he responds.

01/03/02 Mr. Steven Alfano returns for follow up and his left shoulder is doing well post injection. The right shoulder only did well for a few months and then the pain returned. Plan: We discussed his options and he wishes to undergo another arthroscopic decompression and lysis of adhesions and bursectomy. We will evaluate the previous repair to insure that it is intact. The material risks, benefits and alternatives were discussed with the patient who understands and agrees.

02/04/02 Mr. Steven Alfano returns for follow up post arthroscopic decompression/AC resection. Wounds are fine. Sutures are removed. Plan: Continue home exercise program. The patient will return for follow up in four weeks.

03/11/02 Mr. Steven Alfano returns and is doing well except for occasional discomfort over the AC joint. Strength is good. Plan: Start home strengthening program. The patient will return for follow up in six weeks.

MICHAEL M. ALEXIADES, M.D., P.C.
159 EAST 74TH STREET
NEW YORK, N.Y. 10021
TELEPHONE (212) 734-1280

05/05/00 Mr. Steven Alfano returns complaining of lumbar radiculopathy into the left leg for the last couple of weeks. It has gotten quite severe. He is taking Motrin with only minimal relief. Physical Examination reveals normal heel/toe/tandem gait; decreased range of motion of the LS spine; motor is 5 out-of 5; reflexes are 1+ both knees, 2+ both ankles. Plan: We will get an MRI to evaluate for a herniated disc. He is unable at this point to work. We will discuss treatment options after the test.

07/31/00 Mr. Steven Alfano returns with persistent low back pain with occasional numbness in the left leg. He saw a neurologist who felt he had some nerve damage but did not justify surgery. However, his back pain is quite severe despite two epidural injections. He is neurologically intact today although he has difficulty with toe walking. Plan: My recommendation is that he see a spine surgeon for possible fusion at L5-S1.

05/24/01 Mr. Steven Alfano returns for follow up with recurrent right shoulder pain for the last couple of months. He has been doing some weight training to try and build up his shoulder and that may have aggravated it. He has also been going to physical therapy for his back which has gotten worse. He is contemplating surgery with Dr. Farmer at The Hospital for Special Surgery. Physical Examination today is consistent with impingement. He has some crepitus on range of motion. After discussion the patient was injected with Lidocaine and Depo-Medrol. Plan: If symptoms recur we will get an MRI.

11/14/01 Mr. Steven Alfano returns for follow up. Shoulder MRI on the left shows inflammation but no tear. After discussion the patient was injected with Lidocaine and Depo-Medrol. Plan: We will see how he responds.

01/03/02 Mr. Steven Alfano returns for follow up and his left shoulder is doing well post injection. The right shoulder only did well for a few months and then the pain returned. Plan: We discussed his options and he wishes to undergo another arthroscopic decompression and lysis of adhesions and bursectomy. We will evaluate the previous repair to insure that it is intact. The material risks, benefits and alternatives were discussed with the patient who understands and agrees.

01/28/02: HSS "AMB"
01/28/02: SURGERY - RIGHT SHOULDER ARTHROSCOPIC DECOMPRESSION
DISCHARGED

Lenox Hill Hospital, New York City OPERATIVE RECORD

Name ALFANO, STEVEN Date 4/16/03 Hist. No. 1404949

Service of DR. M. ALEXIADES Anesthetist:
Operator(s): DR. M. ALEXIADES Anesthesia: SPINAL
Assistant(s): DR. S. SIEGAL Duration of Oper.:

Preoperative Diagnosis: Right hip labral tear.

Postoperative Diagnosis: Same.

Operation: RIGHT HIP ARTHROSCOPY AND LABRAL RESECTION.

Description: (Incision, Findings, Technique, Sutures, Drains, Culture, Specimen)

Findings: The patient had an inverted labral tear.

Estimated blood loss: Minimal.

Complications: None.

Disposition: The patient was taken in stable condition to the post anesthesia care unit.

Procedure: The patient was brought to the operating room and induced under spinal anesthesia and general sedation. The right lower extremity was prepped and draped in the usual sterile fashion.

Using the fluoroscopy a spinal needle was placed intra-capsularly and the hip was distended with approximately 30 cc of air. The guide wire was placed over the spinal needle after the correct placement had been confirmed with AP and lateral views. A small stab wound was made over the guide wire in order to create the lateral portal. A series of 3 trocars were passed over the guide wire into the hip capsule. The cannula was then introduced over the 5.5 mm trocar and the camera was placed through the cannula. The hip was distracted manually and further distended with the arthroscopy fluid.

The interior of the hip was examined arthroscopically and the inverted labrum was seen freely mobile within the hip joint. Again, an anterior portal was created in a similar fashion under

Name ALFANO, STE[redacted]N Date 4/16/03 Hist. [redacted] 1404949

fluoroscopic guidance. Once the anterior cannula was visible through the lateral trocar the shaver was placed through the anterior portal in order to remove the soft tissue debris. The labrum was well visualized and resected using both the Oratec as well as the shaver device. Once the anterior portion of the labrum was fully resected we switched portals using the anterior portal as a viewing portal and the lateral portal as a working portal.

In a similar fashion the posterior portion of the labrum was resected and the joint was examined arthroscopically. There was minimal chondral damage noted. The labrum had been resected in its entirety. A final last look through the lateral portal confirmed this. The hip was irrigated with copious solution. 30 cc of 0.5% Marcaine was infused into the hip joint and the soft tissues of both the anterior and lateral portals. The portal sites were closed with #2-0 nylon sutures. A sterile dressing was applied.

The traction was released and the patient was transferred to a stretcher and to the recovery room in stable condition.

Dictated by DR. S. SIEGAL
For DR. M. ALEXIADES

SS/HMT325/51438
D: 4/16/03
T: 4/17/03

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Scott R. Gent, M.D.
Karen B. Wagner, M.D.
Debra B. Kessler, M.D.
Shelley E. Wetherbee, M.D.
Peter Reuhmes, M.D.

MICHAEL ALEXIADES, MD
159 EAST 74TH STREET
NEW YORK, NY 10021

Patient Name: STEVEN ALFANO
Date of Birth: 01/14/1958
Identification #: 139521
Accession Number: 140791
Exam Date: 03/24/2003

DEAR DR. ALEXIADES,

RADIOGRAPHS OF: The right hip.

HISTORY: Right hip pain. Evaluate for degenerative change.

FINDINGS: Radiographs of the right hip were obtained in multiple projections. The hip joint space is well-maintained, and the articular surfaces of the bony structures are smooth and normal. The bony structures visualized are seen to be normally mineralized, intact, with no sign of fracture, significant degenerative change, or other bony abnormality. There is no evidence of soft tissue swelling, joint space effusion, or any acute finding.

IMPRESSION: Essentially normal radiographs of the right hip, with no significant acute or chronic radiographic findings.

Thank you for referring this patient.

Electronically Signed By: DAVID FOLLETT, MD 03/24/2003

3/26

Lenox Hill Hospital, New York City OPERATIVE RECORD

Name ALFANO, STEVEN Date 06/13/02 Hist. No. 1404949

Service of: DR. MICHAEL ALEXIADES Anesthetist:
Operator(s): DR. MICHAEL ALEXIADES Anesthesia:
Assistant(s): DR. PAUL S. DEGENFELDER Duration of Oper.:

Preoperative Diagnosis: Left shoulder impingement, acromioclavicular joint arthritis.

Postoperative Diagnosis: Same.

Operation: LEFT SHOULDER ARTHROSCOPY; SUBACROMIAL DECOMPRESSION; ACROMIOCLAVICULAR JOINT RESECTION.

Description: (Incision, Findings, Technique, Sutures, Drains, Culture, Specimen)

Indications: This 44-year-old male was brought to the operating room where scalene block was introduced. The patient was positioned in the beachchair position and left lower extremity was prepped and draped in the usual sterile fashion. The glenohumeral joint was entered using standard posterior portal. Diagnostic arthroscopy performed. There was noted to be no rotator cuff tear or biceps or SLAP lesion. There was some fraying of the anterior labrum.

Next, the subacromial space was entered and the anterolateral portal was made. The 6.0 oval bur was used to do a subacromial decompression resecting a spur from the anterolateral portal. The scope was pushed to the anterolateral portal, and the bur was introduced posteriorly, and this was feathered back smooth with the posterior aspect of the acromion.

Next, using the Arthrocare wand, the soft tissues were debrided from the AC joint and the anteromedial portal was made in line with the AC joint. Using the 6.5 bur, the distal clavicle resected was approximately 9 mm. This was carried out anterior to posterior, inferior to superior. This was confirmed by switching the arthroscope to the anteromedial portal.

Once this was accomplished, the subacromial space was irrigated with normal saline. All instruments were removed. The skin was closed using #4-0 nylon simple sutures. Xeroform and sterile dressing were applied followed by a sling. The patient was transferred to the stretcher

Name ALFANO, STEVEN Date 06/13/02 Hist. No. 1404949

taken to the recovery room where he was noted to be in stable condition having tolerated the procedure well.

There were no complications. Findings were as noted above with large anterior subacromial spur. Dr. Alexiades was present through the entire procedure.

Dictated by DR. PAUL S. DEGENFELDER
For DR. MICHAEL ALEXIADES

PD/HMT322/32998
D: 06/13/02
T: 06/14/02

THE HOSPITAL FOR SPECIAL SURGERY

535 East 70th Street
New York, N.Y. 10021

DEPARTMENT OF RADIOLOGY AND IMAGING

Patient Name
ALFANO,STEVEN A
Ordering Physician
ALEXIADES,MICHAEL M
Adm/Reg Physician
ALEXIADES,MICHAEL M
Consulting Physician

Location
DIS

Medical Record #	Date of Birth	Age
689443	01/14/58	44Y

Check-in Date: 04/30/02 0734

Chk-in #	Order	Exam	
965650	0001	0513	MRI LOW EXTREMITY - RT JOINT

Ord Diag: 719.45-JOINT PAIN-PELVIS

JED

MRI of the right hip:

Magnetic resonance imaging of the right hip was performed utilizing coronal fast inversion recovery followed by coronal, sagittal and axial fast spin echo techniques.

There is no stress fracture, transient marrow ischemia or frank osteonecrosis. No trochanteric bursitis is seen.

Surface coil images of the right hip, slightly degraded due to motion, demonstrate partial thickness cartilage loss in the immediate suprafoveal portion of the femoral head without displaced surface flap or exposure down to subchondral bone. Mild superficial chondromalacia of the posterosuperior margin of the acetabulum is seen with additional mild wear over the anterolateral margin of the dome.

There is a torn degenerated anterior acetabular labrum without associated ganglion cyst formation. Borderline acetabular dysplasia is noted. There is no inflammatory synovitis.

Hip abductors appear preserved. Iliopsoas tendon also appears intact.

Intrapelvically, there is no bulky pelvic adenopathy. Fat-filled inguinal hernias are noted. There is marrow replacement process affecting the proximal left femur with foci of cystic signal

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NEW YORK NY 10021

FINAL

THE HOSPITAL FOR SPECIAL SURGERY

535 East 70th Street
New York, N.Y. 10021

DEPARTMENT OF RADIOLOGY AND IMAGING

Patient Name
ALFANO,STEVEN A
Ordering Physician
ALEXIADES,MICHAEL M
Adm/Reg Physician
ALEXIADES,MICHAEL M
Consulting Physician

Location
DIS

Medical Record #
689443

Date of Birth
01/14/58

Age
44Y

Checkin-Exam Code Summary
965650-0613

hyperintensity as well as relatively hypointensity. There is cortical expansion. Differential possibilities include remnant of cystic fibrous dysplasia, or possibility of a previously treated unicameral bone cyst. This area may be more comprehensively studied with surface coil images when clinically warranted. There is no pathologic fracture and the lesion overall has a nonaggressive appearance.

Impression:

Magnetic resonance imaging of the right hip demonstrating superficial cartilage loss over the hip joint, borderline acetabular dysplasia and a torn, hyperplastic and degenerated anterior acetabular labrum.

There is a marrow replacement process affecting the left femur which overall has a nonaggressive appearance. Differential possibilities are noted, as above.

ICD 9 Code: 843. 8

/Dictated by/ HOLLIS POTTER M.D.
/Personally Viewed & Interpreted by/ HOLLIS POTTER
/Agreed with/Edited Report by/ HOLLIS POTTER M.D.

JED 04/30/02 1637
04/30/02 1835

re: appointment

212-606-8166

ALEXIADES,MICHAEL M
159 EAST 74TH ST

NEW YORK NY 10021

FINAL

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8982AAAA

May 6, 2002

Michael M. Alexiades, M.D.
159 East 74th Street
New York, New York 10021

Dear Dr. Alexiades,

Re: ALFANO, Steven

EXAMINATION OF THE RIGHT HIP with AP view of the PELVIS shows normal width of the right hip joint and well rounded femoral head. No bone lesion, productive change, periarticular calcification, bone lesion or fracture is identified in the right hip.

The PELVIC film shows slight asymmetry of the pelvis due to slight rotation. The left proximal femur shows a large bony lesion.

EXAMINATION OF THE LEFT HIP AND PROXIMAL FEMUR shows a sharply defined 13.5 x 6.5 x 5.5 cm multi-loculated lucent lesion extending from the mid femoral neck into the proximal femoral shaft and slightly expanding the bone. There are multiple punctate, small, rounded and linear calcifications within the lesion, compatible with a chondral lesion. There is no dense sclerotic rim. Adjacent cortex is well maintained with no focal cortical thinning or cortical break. There is no periosteal reaction. The soft tissues around the femur show no soft tissue calcification. The left hip joint appears normal and the femoral head is well rounded with normal texture. Very small apron osteophyte is present, consistent with a mild degenerative change.

IMPRESSION: Large non-aggressive bony lesion expands and remodels the proximal femur from the femoral neck through the proximal shaft and has matrix calcification, compatible with a chondral lesion. Bone Scan is recommended to assess activity of the lesion. Chondrosarcoma is in the differential.

Thank you for referring this patient to us.

Very truly yours,

L. Daniel Neistadt, M.D.

LDN/sm
05/07/02
PM

917-597-6049

5/9 Dr. Neistadt Refer to bone tumor specialist

COPY

THE HOSPITAL FOR SPECIAL SURGERY
OPERATIVE RECORD

Patient Name: ALFANO, STEVEN Date: 1/28/2002 Service: MR# 689443

ATTENDING SURGEON:	M. ALEXIADES, M.D.
OPERATING SURGEON: ASSISTANT:	M. ALEXIADES, M.D. KRISTEN WARNER, M.D.
PRELIMINARY DIAGNOSIS:	IMPINGEMENT RIGHT SHOULDER AND ARTHROFIBROSIS RIGHT SHOULDER.
POSTOPERATIVE DIAGNOSIS:	IMPINGEMENT RIGHT SHOULDER AND ARTHROFIBROSIS RIGHT SHOULDER.
NAME OF OPERATION:	RIGHT SHOULDER ARTHROSCOPIC DECOMPRESSION, DISTAL CLAVICULECTOMY, BURSECTOMY AND LYSIS OF SUBACROMIAL ADHESIONS.
ANESTHESIA: ANESTHESIOLOGIST:	REGIONAL. BRAD CARSON, M.D.

PROCEDURE:
Once the regional anesthesia was administered, the right shoulder was prepped and draped in the usual fashion, after the patient was placed in the beach chair position.

After the shoulder was prepped and draped, the posterior portal incision was made and the arthroscope was placed into the glenohumeral joint. The glenohumeral joint revealed normal articular surfaces, intact anterior labrum, intact ligamentous structures. The articular surfaces were intact. There were no loose bodies. Examination of the biceps tendon revealed it to be intact. Examination of the rotator cuff, supra and infraspinatus, revealed these to be intact.

At this point, the arthroscope was placed into the subacromial space. There was

Continued..

THE HOSPITAL FOR SPECIAL SURGERY
OPERATIVE RECORD

Patient Name: ALFANO, STEVEN Date: 1/28/2002 Service: MR# 689443

a great deal of bursal tissue present and mulliple adhesions, particularly in the region of the acromioclavicular joint. The examination of the superior portion of the cuff, after a bursectomy was performed, by anterolateral portal incision, using the shaver, revealed the rotator cuff to be intact.

There was regrowth of the anterior subacromial spurring as well as medially along the acromioclavicular joint. Utilizing the ArthriCare the soft tissue was resected off of the undersurface of the acromion and the acromion was resected along its undersurface forming a type I acromion using a cutting block technique. Once the subacromial space was adequately decompressed, attention was paid to the acromioclavicular joint.

Using an anterior portal and the ArthriCare, the capsule of the acromioclavicular joint was resected. The distal clavicle was then resected back a distance of approximately 1 cm using a 6.0 oval bur. Once the distal clavicle was resected appropriately, the shoulder was thoroughly irrigated and drained.

The wounds were closed using 4-0 nylon sutures, Xeroform and sterile dressings were applied. The patient was placed in the sling and was taken to the Recovery Room in stable condition.

CC: M. ALEXIADES, M.D.

DATE

M. ALEXIADES, M.D.

Dictated by: ,,/M. ALEXIADES, M.D.
Dict Date: 1/28/2002 Typed by: PMC/pw/24921 Trans Date: 01/29/2002

End

The Hospital for Special Surgery
Department of Orthopedic Pathology

535 East 70th Street
New York, NY 10021

Peter G. Bullough, M.D., Director
(212) 606-1341

PATHOLOGY CONSULTATION REPORT

Case Number: S2002-000870

Patient Name: ALFANO, STEVEN A
Date of Birth: 01 14 1958
Sex: M Age: 44
Location: AMS

Medical Record #: 689443
Account Number: 72505271
Accession Date: 01 29 2002
Operative Date: 01 28 2002

Pathologist: EDWARD F. DICARLO M.D.

Physicians
MICHAEL M ALEXIADES

Clinical Information
Right shoulder impingement
OPERATION PERFORMED: Right shoulder arthroscopy, acromioplasty, distal AC joint resection, decompression

Final Anatomic Diagnosis
JOINT, SHOULDER, SHAVINGS, RIGHT
Degenerative and Proliferative Changes, consistent with Chronic Traumatic Injury

(efd)

Gross Anatomic Description
Specimen Label: Shavings right shoulder
In formalin: The specimen is present in a white fabric sac and consists of multiple pieces of gritty tan soft tissue measuring in aggregate approximately 3 x 3 x 3 cm in greatest dimension. A representative sample is submitted. (EFD/sr)

Material Submitted

Description	*Desig.*	*Type*	*Count*
Undesignated	U	STR	1

Microscopic Description
The section is of multiple fragments of predominantly capsular tissue intermixed with bony debris and skeletal muscle. The capsular tissue shows fibrosis with focal chondroid degeneration at soft tissue bony attachment sites. A small amount of synovium shows slight hyperplasia and slight fibrosis.

EDWARD F. DICARLO M.D.
(Signed out 01 30 2002)

JAN 25 2002 4:37PM ALFANO, STEVEN 120-41-47 NO.131 P.2

01/18/02 6580 77009 CHEST PA AND LATERAL Final

Ordered:01/18/2002 Location: COMPRH CARE-HT4
Order time: 0957
Name: ALFANO, STEVEN
MRN: (00000)002284147
Age: 44 YRS Sex: M DOB:01/14/58
Admitting M.D.:ROACH, KEITH W. MD
Exam Ordered: Order M.D.
CH PA/LAT ROACH, KEITH W. MD

RADIOLOGY REPORT.

EXAM DATE: Accession #:
01/18/02 01-RA-02-006580

FINDINGS:

CHEST PA and LATERAL
FINDINGS:
The heart and mediastinum are normal in shape and density.
The lungs are clear. The pulmonary vessels are normal.
The chest wall and pleura are normal.

IMPRESSION:

IMPRESSION:
Normal radiographic examination of the thorax.
Code: V72.5
HISTORY: Preoperative examination.
Study interpreted and report approved by: Gordon Gamsu M.D.
Electronically signed Diagnostic Imaging Report
/ 18JAN2002/ GG
Exam start / Sign-off / Transcription initials.

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Erich Eidenschenk, M.D.
David A. Follett, M.D.
William Louie, M.D.
Keith S. Tobin, M.D.
Lynn Ladetsky, M.D.
Scott R. Gerst, M.D.

9/17-597-6049

MICHAEL ALEXIADES, MD

Patient: ALFANO, STEVEN ID: 139521 20011031516241395211

MRI LEFT SHOULDER 11/1/01

An MRI examination of the left shoulder was performed using oblique coronal proton density and T2 fat suppression, oblique sagittal T1 and FSE T2 fat suppression, and axial T2 * sequences.

The osseous structures comprising the left shoulder demonstrate normal marrow signal. There is mild degenerative change in the acromioclavicular joint, with only minimal spurring noted at the undersurface. The acromion is slopes laterally downwards, and there is a broad-based small-to-moderate subacromial enthesophyte at the point of attachment of the coracoacromial ligament. There is evidence of significant focal narrowing of the acromiohumeral space along the lateral margin of the acromion. Mild inflammatory change is noted in the underlying subacromial/subdeltoid bursa. No definite full-thickness rotator cuff tear seen, however. The bursal surface of the distal supraspinatus tendon has a fibrillated margin. The infraspinatus, teres minor, subscapularis and long biceps tendons are all intact. There is no joint effusion. There is no evidence of labral detachment.

IMPRESSION:

1. Hypertrophic changes of the acromion, as described above.
2. Mild inflammatory change in the underlying subacromial/subdeltoid bursa.
3. Study negative for full-thickness rotator cuff tear. There is irregularity of the bursal surface of the supraspinatus tendon.

Thank you for referring this patient.
Electronically Signed By: Keith Tobin, MD 11/1/01

11/5

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Carmel Donovan, M.D.
Erich Eldenschenk, M.D.
David A. Follett, M.D.

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JAMES C FARMER, MD

Patient: ALFANO, STEVEN ID: 139523 20010817551501395211

MRI OF THE LUMBAR SPINE 8/18/01:

Sagittal and coronal proton density, sagittal T1 and T2 FSE weighted images of the lumbar spine with axial proton density weighted images of L1-2 through L5-S1 were obtained on a 1.5 Tesla MRI unit. 43 year-old with chronic low back pain and bilateral radiculopathy. Comparison is made to report of prior study 6/9/00.

There is normal lumbar lordosis and alignment. There are no fractures or subluxations. There is moderate-to-severe L5-S1 spondylosis with disc space narrowing, disc desiccation, degenerative type II end-plate marrow change and vacuum disc phenomena. The remaining lumbar intervertebral discs are normal. There are no destructive marrow processes. Small, typical hemangiomata are seen within the L4 and L5 vertebral bodies. The conus medullaris is at the approximate L1-2 level. There are no abnormalities of the distal thoracic spinal cord or conus medullaris. There are no intraspinal mass lesions. The paraspinal soft tissues are grossly normal.
At L1-2 through L3-4, there are no disc protrusions, significant disc bulges spinal stenosis or neural foraminal narrowing.
At L4-5, there is minimal annular disc bulge and moderate facet osteoarthritis. There are mild developmentally shortened pedicles and mild spinal stenosis. There is also mild narrowing of both neural foramen. This shows slight interval increase.
At L5-S1, there is a prominent posterior disc osteophyte complex impinging upon the anterior thecal sac causing moderate spinal stenosis. This disc osteophyte complex measures 8 mm cephalocaudad x 7 mm AP x 20 mm transverse dimension. This has shown slight interval increase in size by report. However direct comparison to prior study is suggested for interval change. There is moderate facet osteoarthritis and mild moderate left sided neural foraminal narrowing.

IMPRESSION:
1. MODERATE-TO-SEVERE L5-S1 SPONDYLOSIS.
2. POSTERIOR DISC OSTEOPHYTE COMPLEX AT L5-S1 CAUSING MODERATE SPINAL STENOSIS.
3. MILD L4-5 SPINAL STENOSIS.

Thank you for referring this patient.
Electronically Signed By: William Louie, MD 8/20/01

LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C.

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MICHAEL ALEXIADES, MD

Patient: ALFANO, STEVEN ID: 139521 20011012347841395211

MRI RIGHT SHOULDER 10/12/01

An MRI examination of the right shoulder was performed using oblique coronal proton density and T2 fat suppression, oblique sagittal T1 and FSE T2 fat suppression, and axial T2 fat-suppression and T2 * sequences.

The osseous structures comprising the right shoulder demonstrate normal marrow signal. There is evidence of prior acromioplasty procedure. The acromial remnant is noted to slope laterally downward, and there is a small broad-based subacromial enthesophyte at the point where the coracoacromial ligament attaches. These changes appear to cause some focal narrowing of the acromiohumeral space. A fluid collection occupies the subacromial/subdeltoid bursa, appearance consistent with bursitis in the moderate range. No definite full-thickness rotator cuff tear is seen distally. There is evidence of some tendinosis of the supraspinatus tendon, and the bursal surface of the tendon appears markedly fibrillated in contour. The infraspinatus, teres minor, subscapularis and long biceps tendons are intact. There is no joint effusion. There is evidence of a small focal defect in the inferior-posterior corner of the labrum; an associated small cluster of perilabral cysts is noted at the site. The remainder of the labrum appears intact.

IMPRESSION:

1. Study negative for full-thickness rotator cuff tear. There is evidence of tendinosis in the distal supraspinatus tendon, and the bursal surface of the tendon appears frayed.
2. Hypertrophic changes of the acromial remnant, as described above.
3. Subacromial/subdeltoid bursitis in the moderate range.
4. Evidence of a focal inferior-posterior labral tear with associated cluster of tiny perilabral cysts.

Thank you for referring this patient.

Electronically Signed By: Keith Tobin, MD 10/12/01

Lenox Hill Hospital, New York City OPERATIVE RECORD

Name ALFANO, STEVEN Date 06/13/02 Hist. No. 1404949

Service of: DR. MICHAEL ALEXIADES Anesthetist:
Operator(s): DR. MICHAEL ALEXIADES Anesthesia:
Assistant(s): DR. PAUL S. DEGENFELDER Duration of Oper.:

Preoperative Diagnosis: Left shoulder impingement, acromioclavicular joint arthritis.

Postoperative Diagnosis: Same.

Operation: LEFT SHOULDER ARTHROSCOPY; SUBACROMIAL DECOMPRESSION; ACROMIOCLAVICULAR JOINT RESECTION.

Description: (Incision, Findings, Technique, Sutures, Drains, Culture, Specimen)

Indications: This 44-year-old male was brought to the operating room where scalene block was introduced. The patient was positioned in the beachchair position and left lower extremity was prepped and draped in the usual sterile fashion. The glenohumeral joint was entered using standard posterior portal. Diagnostic arthroscopy performed. There was noted to be no rotator cuff tear or biceps or SLAP lesion. There was some fraying of the anterior labrum.

Next, the subacromial space was entered and the anterolateral portal was made. The 6.0 oval bur was used to do a subacromial decompression resecting a spur from the anterolateral portal. The scope was pushed to the anterolateral portal, and the bur was introduced posteriorly, and this was feathered back smooth with the posterior aspect of the acromion.

Next, using the Arthrocare wand, the soft tissues were debrided from the AC joint and the anteromedial portal was made in line with the AC joint. Using the 6.5 bur, the distal clavicle resected was approximately 9 mm. This was carried out anterior to posterior, inferior to superior. This was confirmed by switching the arthroscope to the anteromedial portal.

Once this was accomplished, the subacromial space was irrigated with normal saline. All instruments were removed. The skin was closed using #4-0 nylon simple sutures. Xeroform and sterile dressing were applied followed by a sling. The patient was transferred to the stretcher

Name ALFANO, STEVEN Date 06/13/02 Hist. No. 1404949

taken to the recovery room where he was noted to be in stable condition having tolerated the procedure well.

There were no complications. Findings were as noted above with large anterior subacromial spur. Dr. Alexiades was present through the entire procedure.

Dictated by DR. PAUL S. DEGENFELDER
For DR. MICHAEL ALEXIADES

PD/HMT322/32998
D: 06/13/02
T: 06/14/02

Lenox Hill Hospital, New York City OPERATIVE RECORD

Name ALFANO, STEVEN Date 4/16/03 Hist. No. 1404949

Service of DR. M. ALEXIADES Anesthetist:
Operator(s): DR. M. ALEXIADES Anesthesia: SPINAL
Assistant(s): DR. S. SIEGAL Duration of Oper.:

Preoperative Diagnosis: Right hip labral tear.

Postoperative Diagnosis: Same.

Operation: RIGHT HIP ARTHROSCOPY AND LABRAL RESECTION.

Description: (Incision, Findings, Technique, Sutures, Drains, Culture, Specimen)

Findings: The patient had an inverted labral tear.

Estimated blood loss: Minimal.

Complications: None.

Disposition: The patient was taken in stable condition to the post anesthesia care unit.

Procedure: The patient was brought to the operating room and induced under spinal anesthesia and general sedation. The right lower extremity was prepped and draped in the usual sterile fashion.

Using the fluoroscopy a spinal needle was placed intra-capsularly and the hip was distended with approximately 30 cc of air. The guide wire was placed over the spinal needle after the correct placement had been confirmed with AP and lateral views. A small stab wound was made over the guide wire in order to create the lateral portal. A series of 3 trocars were passed over the guide wire into the hip capsule. The cannula was then introduced over the 5.5 mm trocar and the camera was placed through the cannula. The hip was distracted manually and further distended with the arthroscopy fluid.

The interior of the hip was examined arthroscopically and the inverted labrum was seen freely mobile within the hip joint. Again, an anterior portal was created in a similar fashion under

Name ALFANO, STE[redacted]N Date 4/16/03 Hist. [redacted] 1404949

fluoroscopic guidance. Once the anterior cannula was visible through the lateral trocar the shaver was placed through the anterior portal in order to remove the soft tissue debris. The labrum was well visualized and resected using both the Oratec as well as the shaver device. Once the anterior portion of the labrum was fully resected we switched portals using the anterior portal as a viewing portal and the lateral portal as a working portal.

In a similar fashion the posterior portion of the labrum was resected and the joint was examined arthroscopically. There was minimal chondral damage noted. The labrum had been resected in its entirety. A final last look through the lateral portal confirmed this. The hip was irrigated with copious solution. 30 cc of 0.5% Marcaine was infused into the hip joint and the soft tissues of both the anterior and lateral portals. The portal sites were closed with #2-0 nylon sutures. A sterile dressing was applied.

The traction was released and the patient was transferred to a stretcher and to the recovery room in stable condition.

Dictated by DR. S. SIEGAL
For DR. M. ALEXIADES

SS/HMT325/51438
D: 4/16/03
T: 4/17/03

CICM-0373
5.30.07

Roberto Castellon
Senior Case Manager
CIGNA Disability Management Solutions

CIGNA Group Insurance
Life - Accident - Disability

Routing 212E
12225 Greenville Avenue
Suite 1000 LB 179
Dallas, TX 75243-9362
Telephone 1.800.352.0611
Extension 5608
Facsimile 869.731.2907
Roberto.Castellon@Cigna.Com

July 13, 2004

STEVEN ALFANO
3800 WALDO AVENUE, APT. 13-G
BRONX, NY. 10463

Claimant: Steven Alfano
Policyholder: Weill Medical College
Policy No: NYK 1972
Underwriting Company: Life Insurance Company of North America

Dear Mr. Alfano:

This letter is in reference to the above-mentioned claim for long term disability benefits.

Please fully complete the enclosed Disability Questionnaire & Activities of Daily Living form and return it to this office along with the signed authorization within 14 days of receipt of this letter. Please see that your response is returned to this office by **July 27, 2004**. Also, please submit a copy of your current driver's license or identification card.

Should you have any questions concerning this matter, please do not hesitate to contact this office.

Sincerely,

Roberto Castellon
Senior Case Manager

Roberto A. Castellon
Senior Case Manager
CIGNA Disability Management Solutions

CIGNA Group Insurance
Life - Accident - Disability

Routing LB179
12225 Greenville Avenue
Dallas, TX 75243
Telephone (800) 352-0611 Ext. 5608
Facsimile (860)731-2907
Roberto.Castellon@CIGNA.com

July 12, 2004

Steven Alfano
3800 Waldo Avenue, Apt. 13-G
Bronx, NY 10463

Claimant: Steven Alfano
Date of Birth: 01/14/58
Policy No: NYK 1972
Policyholder: Weill Medical College

Dear Mr. Alfano:

This letter is in regard to your Long Term Disability claim.

Your policy has the following provision:

COST OF LIVING ADJUSTMENT

On January 1, any Employee who is entitled to receive a monthly Benefit and has been disabled for 12 months following the end of the Benefit Waiting Period will be eligible for a Cost of Living Adjustment. The Monthly Benefit payable to him, beginning with the month of January, will be increased by 3%.

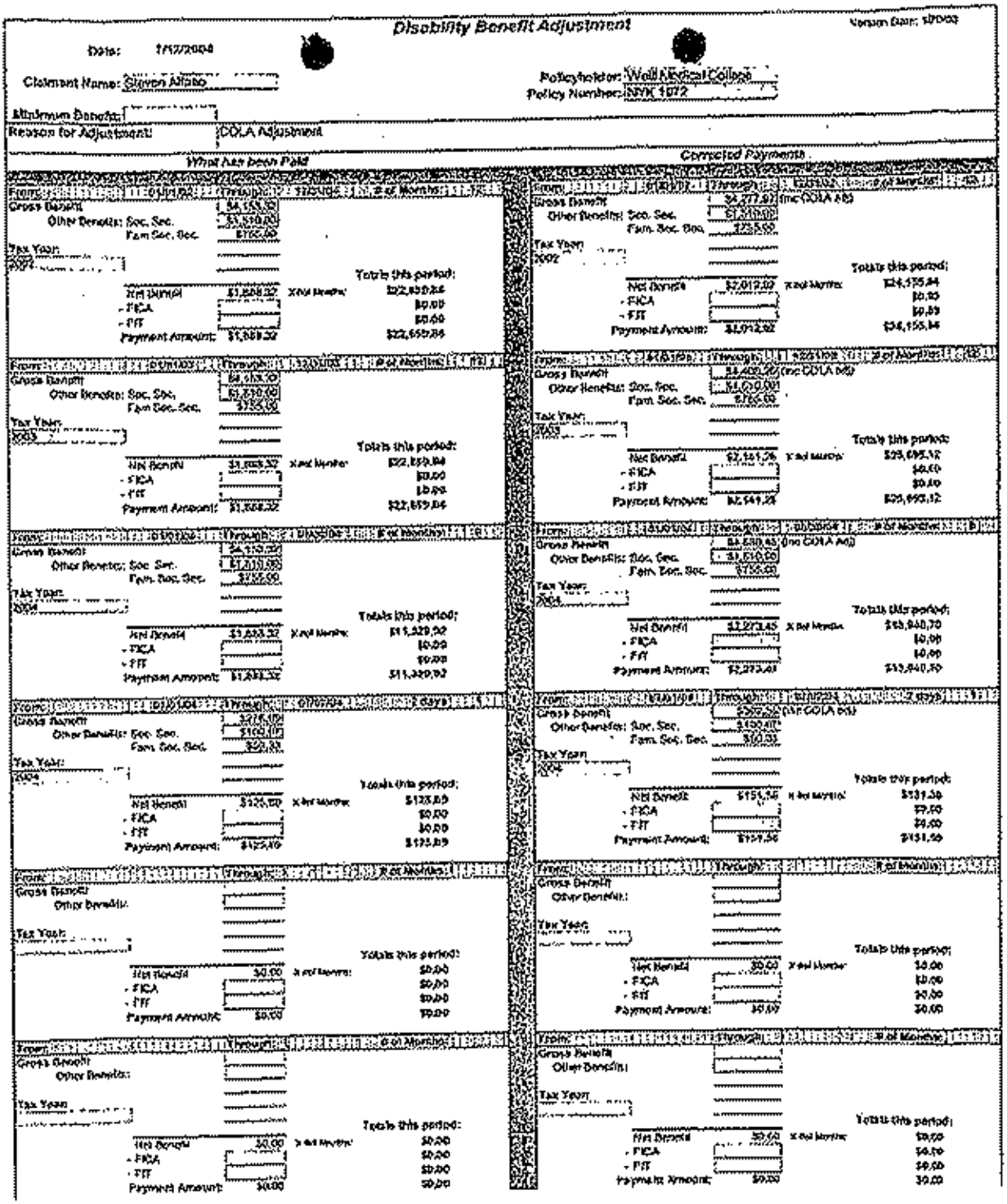
The Cost of Living Adjustment will be determined on each January 1 until a total of 5 annual adjustments have been made. This adjustment will not be subject to the overall maximum Monthly Benefit.

Under separate cover, you will receive a check in the amount of $6,866.93, for the period of 1/1/2002 through 7/2/2004. We have recalculated your disability benefits since no COLA adjustment had been applied to your benefit. A copy of your benefits recalculations is enclosed for your review.

If you have any questions, please feel free to contact me at (800) 352-0611 ext. 5608.

Sincerely,

Roberto Castellon
Sr. Case Manager



Disability Benefit Adjustment

Date: 1/17/2008

Claimant Name: Steven Alfaro

Policyholder: Weill Medical College

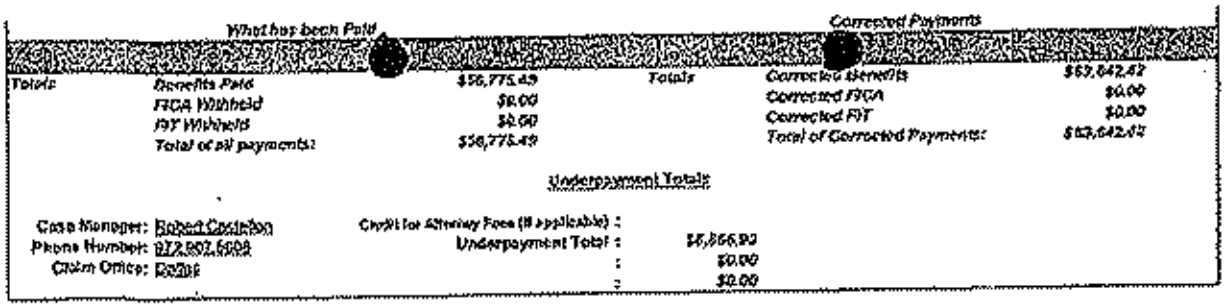
Policy Number: NYK 1072

Minimum Benefit:

Reason for Adjustment: COLA Adjustment

What has been Paid

Corrected Payments



What has been Paid			Corrected Payments		
Totals	Benefits Paid	$56,775.49	Totals	Corrected Benefits	$63,642.42
	FICA Withheld	$0.00		Corrected FICA	$0.00
	FIT Withheld	$0.00		Corrected FIT	$0.00
	Total of all payments:	$56,775.49		Total of Corrected Payments:	$63,642.42

Underpayment Totals

Case Manager: Robert Cavallon
Phone Number: 972.907.5009
Claim Office: Dallas

Credit for Attorney Fees (if applicable) :
Underpayment Total : $6,866.93
: $0.00
: $0.00

COLA ADJ. 1/1/02 - 7/2/04

Gross Benefit = $4,153.32

COLA = 3% up to 5 yrs.

1/1/02 - 12/31/02

$4,153.32 x 3% = $124.60

4153.32 + 124.60 = $4277.92 - New benefit amount

1/1/03 - 12/31/03

$4277.92 x 3% = $128.34

4277.92 + 128.34 = $4,406.26 - new benefit amt

1/1/04 - 7/2/04

$4,406.26 x 3% = $132.19

$4406.26 + 132.19 = $4538.45 - new benefit amt.

08/05/03 09:52am P. 001

Michael M. Alexiades, M.D., P.C.
159 East 74th Street
New York, NY 10021
(212) 734-1288

August 5, 2003

RE: Steven Alfano

To Whom It May Concern:

Please be advised that a disability and physical capabilities form has come to my attention. The fee for this form is $50.00. Please be advised that once payment is received the form will be returned to you as soon as possible.

Yours truly,

Velma
Secretary to
Michael M. Alexiades, M.D.

MMA:vjp

Tax ID# 13-3517927

paid $50.00 8/6/03

JUL. 24. 2003 11:75AM CIGNA DALLAS NO. 315 P. 1

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life - Accident - Disability

Transmit to FAX number	Date	Time	Total number of pages (including this sheet):
212-439-6855	July 24, 2003	12:00 p.m.	

Name Dr. Michael Alexiades	Name Roberto Castellon
Company	Department CIGNA Disability Management Solutions
Phone 212-734-1288	Phone 1.800.352.0611 Extension 5608
Address 159 E 74 St, New York, NY 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

Comments:

RE: Steven Alfano
DOB: 1/14/58

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income), we are in need of the following information:

- **Copies of your progress notes, including diagnostic test and lab results, from 3/1/01 to the present.**
- **A completed Physical Abilities Assessment form (attached).**

We ask that you kindly respond by **8/7/03** to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your **tax identification number.** If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Roberto Castellon
Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial: 860.731.2907

JUL. 24. 2003 11:25AM CIGNA DALLAS NO. 315 P. 1

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life • Accident • Disability

Transmit to FAX number	Date	Time	Total number of pages including this sheet
212-439-6855	July 24, 2003	12:00 p.m.	

Name Dr. Michael Alexiades	Name Roberto Castellon
Company	Department CIGNA Disability Management Solutions
Phone 212-734-1288	Phone 1.800.352.0611 Extension 5608
Address 159 E 74 St. New York, NY 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

Comments

RE: Steven Alfano

DOB: 1/14/58

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Sincerely,

Roberto Castellon
Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial: 860.731.2907

08/05/03 02:20pm P. 002

Michael M. Alexiades, M.D., P.C.
159 East 74th Street
New York, NY 10021

(212) 734-1288

August 5, 2003

RE: Steven Alfano

To Whom It May Concern:

Please be advised that a disability and physical capabilities form has come to my attention. The fee for this form is $50.00. Please be advised that once payment is received the form will be returned to you as soon as possible.

Yours truly,

Velma
Secretary to
Michael M. Alexiades, M.D.

MMA:vjp

P. 1

* * * TRANSMISSION RESULT REPORT(IMMEDIATE TX) (JUL. 24. 2003 11:26AM) * * *

FAX HEADER: CIGNA DALLAS

DATE	TIME	ADDRESS	MODE	TIME	PAGE	RESULT	PERSONAL NAME	FILE
JUL. 24.	11:24AM	12124396855	G3ES	1'44"	P. 4	OK		315

:BATCH
M :MEMORY TX
S :STANDARD
* :PC

C :CONFIDENTIAL
L :SEND LATER
D :DETAIL
R :ROUTING

B :TRANSFER
F :FORWARDING
F :FINE
O :RECEPT. NOTICE REQ.

P :POLLING
E :ECM
> :REDUCTION
A :RECEPT. NOTICE

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life · Accident · Disability

Transmit to FAX number	Date	Time	Total number of pages (including this sheet):
212-439-6855	July 24, 2003	12:00 p.m.	4

Name Dr. Michael Alexiades	Name Roberto Castellon
Company	Department CIGNA Disability Management Solutions
Phone 212-734-3288	Phone 1.800.352.0611 Extension 5608
Address 159 E 74 St. New York, NY 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

Comments

RE: Steven Alfano

DOB: 1/14/58

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Sincerely,

Roberto Castellon
Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial: 860.731.2907

Disability Management Solutions™
Physical Abilities Assessment Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

CIGNA

We are evaluating your patient's disability claim in order to determine functional impairment.
Please document your objective findings *(check below)* and provide copies of supporting reports such as office notes/consultations/testing.
(Failure to provide the requested reports/data may result in delay in claim determination).

Claimant Name:	Date of Birth:
ICD-9 Diagnosis:	

Please check (√) the boxes corresponding to the patient's level of physical functionality. Please substantiate your findings with medical documentation.

In an 8 hour workday, the patient can tolerate, with positional changes and meal breaks, the following activities for the specified durations:

ASSESSMENT OF PHYSICAL ABILITIES	CONTINUOUSLY (67% - 100%) (5.5+ hrs.)	FREQUENTLY (34% - 66%) (2.5 - 5 hrs.)	OCCASIONALLY (1% - 33%) (<2.5 hrs.)	NONE (0%) (0 hrs.)	(CHECK √) IF SUPPORTED BY OBJECTIVE FINDINGS
Sitting:	☐	☐	☐	☐	☐
Standing:	☐	☐	☐	☐	☐
Walking:	☐	☐	☐	☐	☐
Climbing:	☐	☐	☐	☐	☐
Balancing:	☐	☐	☐	☐	☐
Kneeling:	☐	☐	☐	☐	☐
Crawling:	☐	☐	☐	☐	☐
Crouching:	☐	☐	☐	☐	☐
Stooping:	☐	☐	☐	☐	☐
Hearing:	☐	☐	☐	☐	☐
Reaching: Overhead	☐	☐	☐	☐	☐
Desk Level	☐	☐	☐	☐	☐
Below Waist	☐	☐	☐	☐	☐
Seeing:	☐	☐	☐	☐	☐
Smelling/Tasting:	☐	☐	☐	☐	☐
Exposure to Extremes in Heat:	☐	☐	☐	☐	☐
Exposure to Extremes in Cold:	☐	☐	☐	☐	☐
Exposure to Odors/Fumes/Particles:	☐	☐	☐	☐	☐
Ability to Work Extended Hours/DT:	☐	☐	☐	☐	☐
Use of Lower Extremities for Foot Control:	☐	☐	☐	☐	☐
Exposure to Vibration:	☐	☐	☐	☐	☐
Exposure to Wet/Humid Conditions:	☐	☐	☐	☐	☐
Can Work Around Machinery:	☐	☐	☐	☐	☐
Fine Manipulation: Specify frequency and L or R					
Simple Grasp: Specify frequency and L or R					
Firm Grasp: Specify frequency and L or R					

(Continued on Reverse Side)

In the last column check (√) the box which corresponds to the patient's level of physical work function. Please substantiate your findings with medical documentation.

In an 8 hour workday, the patient can tolerate, with positional changes and rest breaks, the following:

PHYSICAL WORK LEVEL (Lift, Carry, Push, Pull)	CONTINUOUSLY Over 2/3 of the day (5 or more Hrs/min.)	FREQUENTLY 1/3 to 2/3 of the day (Up to 4 Hrs/min.)	OCCASIONALLY Up to 1/3 of the day (1 Hr/6 min.)	APPROXIMATE ENERGY REQUIRED IN WORK METS*	MOST APPLICABLE IN YOUR OPINION (Check 1/3 Box)
No Work	None	None	None	None	☐
Sedentary	Negligible *(mostly sitting)*	Negligible	10 lbs. *(standiwalk occasionally)*	1.5 - 2.1	☐
Light	Negligible	10 lbs. *(standiwalk occasionally)*	20 lbs.	2.2 - 3.5	☐
Medium	10 lbs.	10 - 25 lbs.	20 - 50 lbs.	3.6 - 6.3	☐
Heavy	10 - 20 lbs.	25 - 50 lbs.	50 - 100 lbs.	6.4 - 7.5	☐
Very Heavy	20 - 50 lbs.	50 - 100 lbs.	100+ lbs.	Over 7.5	☐

*One MET is equivalent to the amount of energy expended in a resting state, for example sitting in a chair and not moving. Activities can be calculated as multiples of the resting state. Therefore a 2 MET activity would mean the activity requires 2 times the amount of energy required to sit in a chair.

Additional Comments on Functionality:

Physician Name *(Please Print)*:	Medical Specialty:
Address: *(Street, City, State, Zip Code)*	
Telephone Number:	Federal Tax ID #:
Physician Signature:	Date:

Thanks in advance for your prompt response to this request.